United States Department of Labor
Employees' Compensation Appeals Board

M.B., Appellant	)	
and	)	**Docket No. 16-1188**
	)	**Issued: January 10, 2017**
SOCIAL SECURITY ADMINISTRATION, CENTER FOR HUMAN RESOURCES, Baltimore, MD, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On May 13, 2016 appellant, through counsel, filed a timely appeal from a December 9, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

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[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant met her burden of proof to establish a traumatic injury causally related to an accepted September 25, 2014 employment incident.

FACTUAL HISTORY

On October 2, 2014 appellant, then a 51-year-old legal administrative specialist, filed a traumatic injury claim (Form CA-1) alleging that on September 25, 2014 she sustained whole body pain, and bilateral carpal tunnel syndrome when she slipped and fell in a hallway, and then slid into a wall. The claim form does not indicate whether she stopped work.

An employing establishment form dated September 26, 2014 indicated that on September 25, 2014 appellant was walking to her assigned classroom when she slipped and fell on a wet floor. She was treated at employee health and missed approximately 30 minutes of work that morning due to whole body pain.

On November 29, 2014 OWCP received a narrative statement from appellant explaining that she was a disabled veteran and had undergone rehabilitation for the past five years due to injuries she sustained while on active duty. Appellant related that when she fell at work on September 25, 2014 she slid into a wall, and hit her head on a metal rod. She submitted various billing statements for medical treatment that she had received shortly after the September 25, 2014 incident, various physical therapy notes, and a request for an ergonomic chair.

Appellant also provided various medical reports from 2007 for treatment of migraines. She also submitted a June 21, 2010 decision from the Department of Veterans Affairs, which granted her service-connected benefits effective May 6, 2009 for the conditions of gastroesophageal reflux disease, asthma and recurrent bronchitis, left hip strain, and bilateral retinitis pigmentosa, and tropia with diplopia.

Dr. Bhawana Bahethi, a Board-certified internist, indicated in work status notes dated October 1 to November 13, 2014 that appellant should remain off work and could return to normal duty on November 17, 2014.

Appellant was treated in the emergency room on October 9, 2014 by Dr. Bonnie Jo Karr, Board-certified in emergency medicine. Dr. Karr related that, during the previous night, appellant felt nauseated and lightheaded and that morning appellant had experienced "throbbing" tingling from her neck, mild dizziness, blurry vision, ringing in her ear, and unsteady gait when she woke up. She indicated that appellant had a history of migraines and other neurological problems and noted a September 25, 2014 injury. Physical examination revealed no apparent trauma of the head, nontenderness in the extremities, normal range of motion, and normal sensation and motor examination. Dr. Karr reported that a computerized tomography (CT) scan of the head revealed no acute process and an electrocardiogram (EKG) demonstrated normal sinus rhythm. She diagnosed headache, paresthesia, memory impairment, and right-sided weakness.

A CT scan report dated October 9, 2014 by Dr. Anis Frayha, a Board-certified radiologist, revealed no evidence of hemorrhage or acute intracranial process.

In a report dated on October 17, 2014, Dr. Neel K. Vibhakar, Board-certified in emergency medicine, reported that appellant complained of right-sided migraine headache that began that morning, dizziness, and blurred vision. Appellant indicated that she had been treated the previous week for similar symptoms, but the symptoms had resolved except for intermittent headaches. Dr. Vibhakar related that on October 5th appellant fell and hit her head, perhaps losing consciousness. Appellant related that since then she had associated dizziness and blurred vision and that her headache was different than her usual migraine. Dr. Vibhakar reviewed her history and provided findings on physical examination. He diagnosed headache and postconcussive syndrome.

Dr. William Davidson, a Board-certified internist, indicated in an October 31, 2014 note that appellant was examined in his office on that date.

In a November 17, 2014 work status note, Dr. Rani Karipineni, a Board-certified internist, reported that appellant could return to work on November 18, 2014.

Dr. Milan Sanghavi, a Board-certified neurophysiologist, discussed in a December 19, 2014 electromyography (EMG) and nerve conduction velocity (NCV) studies report that appellant's NCV's were within normal limits. He also reported a normal electrodiagnostic study of both upper limbs and no evidence of nerve entrapment.

By letter dated January 5, 2015, OWCP advised appellant that the evidence submitted was insufficient to establish her claim. It requested that she respond to a questionnaire to demonstrate that the September 25, 2014 incident occurred as she described and provide additional medical evidence to establish a diagnosed condition as a result of the work incident.

On January 27, 2015 OWCP received appellant's completed development questionnaire. She related details of the September 25, 2014 incident. Appellant alleged that she experienced excruciating pain, could hardly stand, had blurred vision, and had a headache. She stated that she initially saw a nurse in the employee health unit and then received treatment from her treating physician on October 1, 2014. Appellant resubmitted the October 9 and 17, 2014 hospital records.

In a February 10, 2015 report, Dr. Karipineni indicated that appellant was seen in her office and could return to work the next day.

By decision dated February 13, 2015, OWCP denied appellant's claim. It accepted that the September 25, 2014 work incident occurred in the performance of duty as alleged. OWCP, however, denied the claim because the medical evidence of record failed to establish that appellant sustained a diagnosed medical condition as a result of the accepted September 25, 2014 incident.

On March 6, 2015 OWCP received appellant's request for a telephone hearing. Appellant submitted various VA hospital progress and diagnostic reports dated from 2008 to 2010 for treatment for migraine headaches, peripheral neuropathy, radiculopathy, variable disc

degeneration, neck pain, lumbar pain, right shoulder pain, hammer toe, bilateral knee and left hip problems, disc bulges at C4, C5, and C5, C6, and bilateral carpal tunnel syndrome.

In a February 27, 2015 work status note, Dr. Rashida Stevenson, a Board-certified neurologist, indicated that appellant could return to work on March 2, 2015.

On March 6, 2015 appellant underwent various magnetic resonance imaging (MRI) scans by Dr. Amy Pepperney, a Board-certified diagnostic radiologist. She noted in a lumbar spine MRI scan report that appellant complained of left back pain after a fall in September 2014. Dr. Pepperney diagnosed multilevel degenerative changes. In a brain MRI scan report, she noted appellant's complaints of persistent headache and hypertension. Dr. Pepperney reported a normal MRI scan. She further related in a cervical spine MRI scan report that appellant had evidence of multilevel degenerative changes and small focus of cord signal abnormality at C6-7.

Dr. Stevenson discussed, in a March 13, 2015 narrative report, that appellant had a history of bilateral carpal tunnel syndrome, migraines, and head trauma since 2008 due to an injury she sustained in the military while deployed overseas. She indicated that appellant had received medical treatment and was doing well until a fall at work on September 25, 2014. Dr. Stevenson noted that, the next day, appellant was sore and had trouble walking and soon after started to get headaches. Appellant explained that these headaches were different from her previous headaches because the current headaches were associated with blurred or fuzzy vision. Dr. Stevenson noted that appellant also complained of upper back and neck pain and rectal bleeding after the September 25, 2014 fall at work. Upon examination, she observed normocephalic and atraumatic head trauma. Cranial nerve examination revealed normal pupil sizes, normal hearing and swallowing, and no tremors. Dr. Stevenson diagnosed chronic back pain, cervical radiculopathy, and migraines. In a March 13, 2015 physician's report form, she also noted diagnoses of cervical radiculopathy and lumbar radiculopathy. Dr. Stevenson related that appellant was on prescription medication and that her prognosis was fair.

Appellant was also treated by Dr. Amiel W. Bethel, a Board-certified neurological surgeon, who noted in an April 8, 2015 progress report and June 2, 2015 disability note that she complained of cervical and lumbar pain with associated numbness, leg pain, tingling, and weakness. Dr. Bethel reviewed her history and provided findings on examination. He noted diagnoses of cervical spondylosis and lumbar degenerative disc disease. In a June 2, 2015 disability note, Dr. Bethel indicated that he examined appellant that day and diagnosed lumbar degenerative disc disease and stenosis.

In an April 17, 2015 narrative report, Dr. David Cho, a chiropractor, related appellant's complaints of severe neck pain radiating into the bilateral shoulders, hands, and lower back as a result of a fall at work on September 25, 2014. He reviewed the medical treatment she received and provided findings on physical examination. Dr. Cho opined: "it is difficult to determine whether her current symptoms are or are not directly and causally related to her injury at work seven months ago due to lack of examination findings following the injury."

Dr. Karipineni continued to treat appellant and in a May 19, 2015 report indicated that appellant was examined in her office and would be able to return to work on May 20, 2015.

Appellant was treated in the emergency room on May 26, 2015 by Dr. Gregory P. Tokarsky, Board-certified in emergency medicine, who indicated in hospital records that appellant was treated for neck pain and lumbar sciatica.

Dr. Stevenson continued to treat appellant and in a July 24, 2015 narrative report provided a history of appellant's preexisting conditions and her symptoms following the September 25, 2014 work incident. She noted that a March 2015 MRI scan of the cervical spine demonstrated that her previously diagnosed C4 left neural foraminal narrowing was now severe and the L2 and L3 disc protrusion was worse since 2007. Upon examination, Dr. Stevenson observed 5-/5 plantar flexion motor strength, 5-/5 hip flexion motor strength, 5-/5 knee flexion motor strength and decreased sensation at left lower leg compared to right. She noted diagnoses of carpal tunnel syndrome, cervical root lesions, backache, and unspecified migraine. Dr. Stevenson reported that it was unlikely that appellant's overall condition would improve and that she remained disabled.

On July 13, 2015 appellant underwent lumbar surgery.

On October 7, 2015 a telephone hearing was held. Appellant described the September 25, 2014 slip and fall incident at work and stated that she slid and bounced off the walls hitting her head and back. She related that she experienced injuries to her neck, bilateral shoulders, both hands, right foot, and left hip radiating down the left leg. Appellant reviewed the medical treatment she received for sprains in her hand, foot, and back, and for migraine headaches, including back surgery in July 2015. She reported that Dr. Stevenson, her neurologist, was the physician who she felt knew her the best. Appellant noted that she had various preexisting injuries, which she sustained while serving in the military. She mentioned that she underwent rehabilitation and received medical treatment and had been able to work at the employing establishment for four and a half years without incident.

By decision dated December 9, 2015, an OWCP hearing representative affirmed the February 13, 2015 decision with modification. She determined that the medical evidence of record was sufficient to establish diagnoses of migraine headaches, lumbar and cervical radiculopathy, and carpal tunnel syndrome, but denied appellant's claim because the medical evidence failed to demonstrate that these medical conditions were causally related to the September 25, 2014 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence[4] including that he or she sustained an injury in the performance of duty and that any

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[3] *Id.*

[4] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[5]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether "fact of injury" has been established.[6] There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that she actually experienced the employment incident at the time, place, and in the manner alleged.[7] Second, the employee must submit evidence, generally only in the form of probative medical evidence, to establish that the employment incident caused a personal injury.[8] An employee may establish that the employment incident occurred as alleged, but fail to show that his or her disability or condition relates to the employment incident.[9]

Whether an employee sustained an injury in the performance of duty requires the submission of rationalized medical opinion evidence.[10] The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[11] The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[12]

ANALYSIS

Appellant alleged that on September 25, 2014 she sustained multiple injuries to her neck, back, and shoulders as well as neurological conditions as a result of slipping and falling down at work. OWCP accepted that the incident occurred as alleged and that she was diagnosed with migraine headaches, lumbar and cervical radiculopathy, and carpal tunnel syndrome. It denied appellant's claim because the medical evidence failed to establish that her medical conditions were causally related to the September 25, 2014 incident. The Board finds that she has failed to establish an injury causally related to the accepted employment incident.

Appellant received treatment from Dr. Stevenson in narrative reports dated March 13 and July 24, 2015. Dr. Stevenson discussed appellant's history of bilateral carpal tunnel syndrome,

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[5] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[6] *S.P.,* 59 ECAB 184 (2007); *Alvin V. Gadd,* 57 ECAB 172 (2005).

[7] *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

[8] *David Apgar,* 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

[9] *T.H.,* 59 ECAB 388 (2008); *see also Roma A. Mortenson-Kindschi,* 57 ECAB 418 (2006).

[10] *See J.Z.,* 58 ECAB 529 (2007); *Paul E. Thams,* 56 ECAB 503 (2005).

[11] *I.J.,* 59 ECAB 408 (2008); *Victor J. Woodhams,* 41 ECAB 465 (2005).

[12] *James Mack,* 43 ECAB 321 (1991).

migraines, and head trauma since a 2008 injury in the military. She related that appellant had received medical treatment and was doing well until September 25, 2014 when she fell down at work. Dr. Stevenson noted that appellant complained of upper back and neck pain, rectal bleeding, soreness, blurred or fuzzy vision, difficulty walking, and headaches since the fall at work. Upon examination, she observed normocephalic and atraumatic head trauma. Dr. Stevenson diagnosed carpal tunnel syndrome, cervical root lesions, backache, and unspecified migraine. Although she described the September 25, 2014 slip and fall incident at work and provided a medical diagnosis she failed to provide a reasoned explanation of how the specific incident on September 25, 2014 caused or aggravated a medical condition. A physician must provide a narrative description of the identified employment incident and a reasoned opinion on whether the employment incident described caused or contributed to appellant's diagnosed medical condition.[13] The Board notes that this is particularly important in light of appellant's various preexisting conditions.[14] As Dr. Stevenson offered no medical explanation as to how the accepted incident would have physiologically caused the diagnosed conditions, her opinion is of limited value in establishing causal relationship.[15]

Appellant was treated in the emergency room on several occasions following the September 25, 2014 incident. In October 9, 2014 hospital records, Dr. Karr described that appellant experienced "throbbing" tingling from her neck, mild dizziness, blurry vision, ringing in her ears, and unsteady gait when she woke up that morning. She provided examination findings and diagnosed headache, paresthesia, memory impairment, and right-sided weakness. In an October 17, 2014 report, Dr. Vibhakar provided examination findings and diagnosed headache and postconcussive syndrome. In a May 26, 2015 emergency room report, Dr. Tokarsky indicated that appellant was treated for neck pain and lumbar sciatica. The Board notes that none of the emergency room physicians provided any opinion on the cause of appellant's various diagnosed conditions. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[16] Similarly, Dr. Pepperney's March 6, 2015 diagnostic examination reports and Dr. Bethel's April 8 and June 2, 2015 notes offered diagnoses, but also failed to contain an opinion on whether the September 25, 2014 work incident caused the diagnosed condition. For this reason, these reports fail to establish appellant's claim.[17]

Appellant also provided work status notes dated October 1 to November 13, 2014 of Dr. Bahethi, work status notes dated November 17, 2014 to May 19, 2015 of Dr. Karipineni, and an October 31, 2014 medical note of Dr. Davidson. These notes, however, merely indicated that appellant received medical treatment, but fail to diagnosis a condition or offer any opinion

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[13] *John W. Montoya,* 54 ECAB 306 (2003).

[14] *See B.R.,* Docket No. 16-0456 (issued April 25, 2016).

[15] *B.A.*, Docket No. 15-1277 (issued September 7, 2016).

[16] *C.B.,* Docket No. 09-2027 (issued May 12, 2010); *J.F.,* Docket No. 09-1061 (issued November 17, 2009); *A.D.,* 58 ECAB 149 (2006).

[17] *Id*.

regarding causal relationship.[18] The October 9, 2014 CT examination report by Dr. Frayha and December 19, 2014 EMG/NCV examination report by Dr. Sanghavi also fail to establish appellant's traumatic injury claim as their findings were within normal limits with no evidence of abnormalities. These reports fail to establish that appellant sustained a traumatic injury.[19]

OWCP also received an April 17, 2015 report from Chiropractor Cho. Section 8101(2) of FECA[20] provides that the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist. Chiropractor Cho did not indicate that he had taken x-rays of appellant's spine and he did not diagnose a subluxation of the spine. Without a diagnosis of spinal subluxation from an x-ray, a chiropractor is not considered a physician under FECA and his opinion does not constitute competent medical evidence.[21]

Finally, the Board notes that OWCP received reports from a nurse and a physician assistant. Reports from physician assistants or nurses do not constitute competent medical evidence under FECA as they are not considered physicians by section 8101(2) of FECA.[22]

On appeal, counsel contends that appellant submitted sufficient evidence to establish her claim. As explained above, however, the medical evidence of record is insufficient to establish that appellant sustained a traumatic injury as a result of the September 25, 2014 employment incident. Causal relationship is a medical question that must be established by probative medical opinion from a physician.[23] The mere fact that work activities may produce symptoms revelatory of an underlying condition does not raise an inference of an employment relation. Such a relationship must be shown by rationalized medical evidence of a causal relation based upon a specific and accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.[24]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

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[18] *See supra* note 10.

[19] *Id*.

[20] 5 U.S.C. § 8101(2).

[21] *T.W.*, Docket No. 16-0280 (issued September 12, 2016).

[22] 5 U.S.C. § 8101(2) provides that a physician includes, surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law. *V.C.,* Docket No. 16-0642 (issued April 19, 2016); *Allen C. Hundley,* 53 ECAB 551 (2002).

[23] *W.W.,* Docket No. 09-1619 (issued June 2010); *David Apgar, supra* note 8.

[24] *Patricia J. Bolleter,* 40 ECAB 373 (1988).

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a traumatic injury causally related to a September 25, 2014 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the December 9, 2015 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 10, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board